IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
NORTHERN DIVISION

NO. 3:23-CV-614-CWR-LGI

IN RE: JACKSON WATER CASES

J.W., *a minor, et al.,*

Plaintiffs,

v.

The City of Jackson, Mississippi, *et al.,* *Defendants.*

PLAINTIFF'S FACT SHEET

INSTRUCTIONS AND DEFINITIONS

Please fill out a separate Plaintiff's Fact Sheet ("PFS") for each person on whose behalf a claim is being made. Each question must be answered in full. The purpose of this PFS is to obtain accurate information about basic facts that are relevant to claims you asserted in *In re: Jackson Water Cases*: Case No. 3:23-CV-614-CWR-LGI ("JWC Litigation") concerning allegations of exposure to lead in the distribution of water from the City of Jackson. In completing this PFS, you are under oath and must provide information that is true and correct to the best of your knowledge. Information in the PFS may be used as evidence at the trial in this case. If you cannot provide all the details requested, please provide as much information as you can. Please do not leave any blank answers. Where appropriate, please indicate "none," "do not know," or "not applicable." In addition, you must supplement your responses if you learn later that they are incomplete or incorrect in any material respect.

To the extent you have information that does not fit within the space provided for any of the sections or tables in the PFS, you must provide that information on a General Addendum to the PFS. Each additional response or piece of information provided in a General Addendum must identify the Section number of the PFS to which the additional information pertains. Failure to provide complete answers (including on an addendum when necessary) is a failure to comply with the rules governing discovery in this action.

If you are making a claim for injuries or losses you claim that you yourself have suffered because of exposure to lead in the distribution of water from the City of Jackson, you must complete a PFS for yourself. If you are making a claim on behalf of a child for injuries or losses you claim the child suffered because of exposure to lead in the distribution of water from the City

EXHIBIT "B"

of Jackson, then you must complete a separate PFS for each child on whose behalf you are making a claim.

It may be that you do not have all the information you would need to give complete answers to some of the questions in this PFS. If that is the case, you are still required to provide all the information you do have, even though it is not complete. It is also important to understand that, in completing the PFS, you may not rely just on your memory if you have in your possession, or easily available to you, documents, reports, e-mails, text messages, voicemails, or other written or electronic information that you can consult in order to obtain the requested information. Your answers to the questions in the PFS must be as complete and accurate as you can make them, even if answering requires you to devote time and effort to finding and reviewing written and electronic information available to you. Also, please remember that you cannot object to the questions, but must provide the information requested to the best of your ability.

Please note that information deemed to be confidential by a protective order agreed upon between Plaintiff and Defense counsel and entered in the JWC Litigation (including social security numbers) will be treated confidentially by the parties pursuant to the terms of the protective order.

Once you complete the PFS, you should forward it to your attorney. Please consult with your attorney as to the deadline for completion of the PFS.

In completing the PFS, please use the following definitions:

"Plaintiff," "Plaintiffs," "you," and "your," means the adult and/or child referenced in the PFS.

"Birth Mother" refers to the mother of any Plaintiff Child alleged to have suffered an injury as the result of consumption of contaminated water while the mother was pregnant with any Plaintiff Child or when breastfeeding.

"Plaintiff Child" refers to the child allegedly exposed to contaminated water in utero or post-birth that allegedly developed an injury as a result of exposure to or consumption of contaminated water.

"Document" means any writing or record of every type that is in your possession, custody or control or in the possession, custody, or control of your counsel, including but not limited to written documents, documents in electronic format, cassettes, e-mails, videotapes, photographs, charts, computer discs, thumb drives, external hard drives, x-rays, drawings, graphs, phone records, and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into any reasonable usable form.

"Health care provider" or **"health care practitioner"** means any doctor, physician's assistant, nurse practitioner, osteopath, or other individual health care professional regardless of title; hospital, clinic, urgent care, ready care, community health or medical center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical care or advice; and any pharmacy, x-ray department, radiology department, laboratory, physical therapist,

occupational therapist, dentist, audiologist, ophthalmologist, psychiatrist, psychologist, or any other persons or entities involved in the care or treatment of you, or of the person for whom you are completing the Fact Sheet.

"Mental health care provider" means any psychiatrist, psychologist, therapist, or provider of mental health care evaluation, diagnosis, and/or treatment.

"Plumbing" means any service lines, piping, or other fixtures or appliances through which water from the City of Jackson is or was conveyed from the municipal water main to the water faucets, showers, toilets, etc. within a residence or other building.

You are requested to produce documents, as defined above, in response to certain questions in this Fact Sheet that pertain to the incident, injuries, claims, or damages that are the subject of your complaint.

I. BACKGROUND INFORMATION

A. CASE INFORMATION [to be completed by your attorney]

1. PLAINTIFF'S FULL NAME: _____

2. CASE NAME: _____

3. CASE NUMBER: _____

4. LAW FIRM: _____

5. TYPE OF ALLEGED INJURY/INJURIES OR DAMAGE (fill in all that apply to the plaintiff to whom this Fact Sheet applies):

_____CHILD PERSONAL INJURY

_____ADULT PERSONAL INJURY

_____PROPERTY DAMAGE/LOSS

_____OTHER: _____

B. INFORMATION ABOUT PERSON COMPLETING THIS PFS

1. Full Name: _____
(Last Name) (First Name) (Middle Initial)

2. Previous Names: _____
(Last Name) (First Name) (Middle Initial)

3. Date of Birth: _____
(Month/Day/Year)

4. Place of Birth: _____

5. Social Security Number: _____

6. Male or Female: _____Male _____Female ***(If other, please identify)***

7. Present Residential Address: _____

* Street Address (including any apartment or unit number)

_____ _____ _____
City/Town State Zip Code

8. Dates at this Address: _____
(From) – (To)

9. Other residential addresses between January 1, 2006, and the date of completion of this PFS, and dates as to each. (Use additional sheets if necessary):

_____

10. Did you own any of the residential addresses listed in response to question 9, above? If yes, please list the date(s) of ownership of each residential address.

_____

C. REPRESENTATION OF ANOTHER PERSON

If you are completing this PFS for yourself, please skip to Section IV.

If you are completing this PFS as a representative of someone else (i.e., on behalf of a minor or an estate), please complete the following for them:

1. The name of the individual or estate: _____

2. Describe the capacity in which you are representing the individual or estate (e.g., parent, guardian, next friend, or administrator):

_____

3. If you were appointed as a representative by a court, state the following or attach a copy of the order appointing you:

a. The court which appointed you: _____

b. The date of your appointment: _____

Please attach a copy of the order of appointment.

4. What is your relationship to the individual you represent?

_____

5. Have you filed another personal injury lawsuit or any other type of claim on behalf of the person or estate identified in response to question C.1. with respect to allegations in the Complaint?

YES _____ NO _____

If "YES," please fill in the table below:

	Lawsuit or Claim 1	**Lawsuit or Claim 2**	**Lawsuit or Claim 3**
Case Name and Number			
Jurisdiction			
Date of Filing			
Nature of Claim			
Injury Claimed			
Status			
Plaintiffs' Counsel			

6. if you are completing this PFS as a representative, please provide the following information regarding the person for whom you are filling out the PFS:

a. Full Name: _____
(Last Name) (First Name) (Middle Initial)

b. Previous Names: _____
(Last Name) (First Name) (Middle Initial)

c. Date of Birth: _____
(Month/Day/Year)

d. Place of Birth: _____

e. Birth Mother Name: _____

f. Social Security Number: _____

g. Male or Female: _____Male _____Female

h. Present Residential Address: _____
(Street Address (including any apartment or unit number)

_____ _____ _____
City/Town State Zip Code

i. Dates at this Address: _____
(From) – (To)

j. Separately List Prior Addresses since January 2015:

_____

k. Dates at each Address:

_____
(From) – (To)

II. INFORMATION REGARDING WATER TESTING

All Plaintiffs should complete this section.

A. For all addresses where the Plaintiff on whose behalf the Complaint was filed resided on or after January of 2015, please complete the table below and provide the information requested. (Use additional sheets if necessary.)

	Address 1	**Address 2**	**Address 3**	**Address 4**
Were any addresses serviced before December 2023, by water service lines that were made entirely or partially from lead? (Yes, No, or I Do Not Know)				

Any lead plumbing within the residence or property (that is, plumbing through which water from outside traveled to faucets, showers, bathtubs, dishwashers, water heaters, washing machines, etc.) before December 2023? (Yes, No, or I Do Not Know)				
Were water samples collected from the address tested for lead or other contaminants since January of 2015? (Yes, No, or I Do Not Know)				

B. If you answered "yes" to the question in the table above concerning testing for lead or other contaminants, state to the best of your knowledge the date(s) when water lead testing was done, the person requesting the sampling/testing, the person taking the sample, the facility or laboratory which performed the testing and the test results:

1. Address(es) where testing was performed:

_____

1. Dates water sample(s) was collected and tested:

_____

2. Name(s) of person(s) requesting sampling/testing:

_____

3. Name(s) of person(s) or entity(ies) who collected the sample:

_____

4. Facility(ies)/Lab(s) or agency(ies) which performed test:

_____

5. Results:

_____

Please attach copies of any water lead test results in your possession or control and any other documents identifying test results in your possession or control.

III. INFORMATION REGARDING RESIDENTIAL ADDRESSES

All Plaintiffs should complete this section.

A. Does your child live in or regularly (meaning at least six hours a week) visit a home, daycare, or other building built before 1950?

YES_____ NO_____

B. For all addresses listed in response to questions I.B.7, B.9., and II.A-B, please complete the table below and provide the information requested. (Use additional sheets if necessary.)

	Address 1	**Address 2**	**Address 3**	**Address 4**
Were any addresses completely or partially constructed, demolished, painted, remediated, or restored? (Yes, No, or I Do not Know)				
Was any contractor or other individual engaged to completely or partially construct, demolish, paint, remediate, or restore, any address(es)? (Yes,				

No, or I Do not Know)				
Was any lead abatement, removal or remediation performed at any address(es)? ("Yes," "No," or "I Don't Know")				
Were water filters of any sort ever removed, installed, or affixed at any address(es)? ("Yes," "No," or "I Don't Know"				

1. If you answered "yes" to the question in the table above concerning any of the addresses identified, state to the best of your knowledge:

   a. Address(es) where the construction, abatement, demolition, painting, remediation, or installation was performed:

   _____

   b. Dates construction, abatement, removal, painting, remediation, or installation was performed:

   _____

   c. Name(s) of person(s) or entities requesting or ordering construction, abatement, removal, painting, remediation, or installation:

   _____

   d. Name(s) of person(s) or entity(ies) who performed the construction, abatement, removal, painting, remediation, or installation was performed:

   _____

e. Agency, board or authority authorizing construction, demolition, painting, remediation, restoration, or other service described above:

_____

IV. CHILD PERSONAL INJURY CLAIMS

Complete this section only if you allege personal injuries on behalf of a Plaintiff Child. In this section, "you" refers to the Plaintiff Child. You must complete a separate Plaintiff Fact Sheet for each Plaintiff Child.

1. LEAD EXPOSURE

Do you claim that you have been injured because of exposure to lead in water distributed by the City of Jackson at any time since January 2015?

YES_____ NO_____

1. If your answer to the foregoing question is "YES," please identify which of the following injuries you claim you suffered (as identified in Paragraph 59 of the Amended Complaint):

	Yes/No	Date of Onset	Diagnosing Physician/Healthcare Provider Name and Address	Treatment Prescribed if any
Hair Loss				
Skin Rashes				
Digestive and/or Other Organ Problems				
Physical Pain and Suffering				
Mental Anguish				
Fright and Shock				
Disability				
Denial of Social Pleasures and Enjoyments, Embarrassments,				

Humiliation and Mortification				
Brain and/or Developmental Injuries/Cognitive Deficits				
Aggravation of Pre-Existing Injuries (Identify the pre-existing injury you claim has been aggravated)				

2. If you claim any injury not identified above, please set forth below any additional injuries you claim you suffered because of exposure to lead in water distributed by the City of Jackson, the diagnosing healthcare provider and address, date of onset, and treatment prescribed, if any:

_____

3. If you answered "YES" to question IV.A., state to the best of your knowledge each date on which you have undergone testing for lead levels, identify who took the sample to be tested, type of testing (e.g., blood lead, bone mineral study, hair analysis, urinalysis, tooth analysis), and provide the reported results of the testing.

	Test 1	**Test 2**	**Test 3**	**Test 4**
Date of Test for Lead?				
Who took the sample to be tested? (Lab/Facility/Healthcare Provider)				
Type of Testing (e.g., blood lead, bone mineral study, hair analysis, urinalysis, tooth analysis)				
Results of Test				

Please attach copies of any lead test results in your possession or control and any other documents (e.g., medical records) identifying lead test results in your possession or control.

2. HEALTHCARE PROVIDERS

1. Have you been told at any time by any health care provider that you have been injured as a result of lead or other contaminants in water distributed by the City of Jackson?

YES_____ NO_____

2. If "YES," please identify the health care provider(s), state what you were told to the best of your ability and provide the date(s) you were told this. (Attach additional sheets as necessary, and please attach copies of any written statements or medical records on this issue by the health care provider).

- Name and Address of health care provider:

_____

- What were you told:

_____

- Dates you were told:

_____

For each healthcare provider identified above, please complete the medical records authorization and mental health authorization attached hereto.

3. Has the Plaintiff Child undergone any cognitive or behavioral testing or assessments? If yes, please identify any such testing or assessment, provide the following information for any healthcare providers who have conducted cognitive or behavioral testing or assessments on the Plaintiff Child with

regards to the Plaintiff Child's treatment or evaluation for cognitive or behavioral conditions.

Healthcare Professional Name	Healthcare Provider's Specialty	Address	Contact Information (Phone and Email)	Time Period of Treatment	Reason for Treatment

4. Do you claim you have suffered from any other illness because of exposure to lead in water distributed by the City of Jackson at any time since January 2015?

YES_____ NO_____

5. If you answered "YES" to IV.C.4, please state what other illness(es) you allege you have suffered because of exposure to water distributed by the City of Jackson.

_____

6. If you answered "YES" to section IV.C.4., please state whether you have been told by any health care provider that you have suffered from an illness which the health care provider believes was caused by exposure to water distributed by the City of Jackson at any time since January 2015. If so, please identify the health care provider(s), state what you were told to the best of your ability and provide the date(s) you were told this. (Attach additional sheets as necessary). If no health care provider has told you or the child that the child has suffered from any one or more of the diseases you identified above because of exposure to water distributed by the City of Jackson, state with respect to that illness "None."

_____

7. Please identify each of your health care providers (including doctors, nurse practitioners, dentists, mental health care providers, and other health care

professionals, institutions, hospitals, clinics, and urgent care facilities) from January 1, 2004, to the present in the table below.

Health Care Provider	Address	Treatment Dates	Reason for Treatment

For each healthcare provider identified above, please complete the medical records authorization and mental health authorization attached hereto.

3. TREATMENT

1. Has any health care provider prescribed medications to treat your alleged injuries?

YES _____ NO _____

2. If you answered "YES" to the preceding question, please identify the following. **(Use additional sheets as necessary to respond fully and completely)**:

a. Name and Address of health care provider:

_____

b. Medication(s) prescribed:

_____

c. Dates of use of medication(s):

_____

d. Name and address of pharmacy that filled the prescription(s):

_____

For each pharmacy identified above, please complete the medical records authorization and mental health authorization attached hereto.

4. BIRTH MOTHER

Complete this section for any Plaintiff child alleged to have suffered an injury as a result of consumption of contaminated City of Jackson water while the Birth Mother was pregnant with the Plaintiff Child or when breastfeeding.

1. Is Birth Mother different than adult Plaintiff filling out this PFS?

YES_____ NO_____

2. Please provide the following information regarding Birth Mother:

a. Full name: _____

b. Maiden name, or other names used, and dates Birth Mother used those names:

Birth Mother's Name(s)	Date(s) Used (MM/YYYY to MM/YYYY)

c. Date of Birth: _____
(MM/DD/YYYY)

d. Place of Birth: _____
(City, State, Zip Code, Country)

e. Do you have a Social Security Number?

YES_____ NO_____

i. If "YES," please provide it:

_____
(XXX-XX-XXXX)

ii. If "NO," please provide your Driver's License Number or State Identification Number, and the issuing state:

_____

f. Identify each address at which the Birth Mother resided while pregnant with each Plaintiff Child with claims asserted

in this case and the approximate dates the Birth Mother resided at each.

Address (Street Address, City, State, Zip Code, Country)	Dates of Residence (MM/YYYY to MM/YYYY)

2. Has Birth Mother ever filed another personal injury claim with respect to the injuries alleged in the Complaint on behalf of the Plaintiff Child?

YES_____ NO_____

3. Has Birth Mother ever filed another personal injury lawsuit on behalf of the Plaintiff Child?

YES_____ NO_____

If you answered "YES" to question 3 or 4 above, please fill out the table below:

Case Name and Number	Jurisdiction	Date of Filing	Nature of Claim	Injury Claimed	Status	Plaintiffs' Counsel

4. Did the Birth Mother of the Plaintiff Child use tobacco, in any form, at any time during her pregnancy with the Plaintiff Child, or after while breastfeeding?

Check Yes/No: Yes ☐ No ☐

If "Yes," please answer the following:

a. Type of tobacco:

_____

b. Date on which Birth Mother began using tobacco:

_____

c. Date on which Birth Mother ceased using tobacco:

_____

d. Amount of tobacco used while Plaintiff Child was in utero: ___ per day.

e. Amount of tobacco used while breastfeeding: _____ per day.

5. Did the Birth Mother reside with any individual who smoked tobacco at any time during her pregnancy with the Plaintiff Child, or after, while breastfeeding?

Check Yes/No: Yes ☐ No ☐

If "Yes," please answer the following:

a. Name of individual who smoked tobacco:

_____

6. Did the Birth Mother consume marijuana, illicit drugs, or prescription medications at any time during her pregnancy with the Plaintiff Child, or after, while breastfeeding?

Check Yes/No: Yes ☐ No ☐

If "Yes," please fill out the following table:

Substance	Method of Consumption	Amount Consumed	Approximate Date(s) of Consumption (if known)	Frequency (how often)

V. EDUCATION FOR CHILD

A. Is your Plaintiff Child currently enrolled in school?

YES: _____ NO: _____

B. What is the highest level of education that Plaintiff Child completed:

_____

1. Please list any schools you have attended (elementary, middle, junior high or high schools, junior colleges, vocational schools, universities, institutes, or seminaries):

- Name of school:

  _____

- Address:

  _____

- Years of Attendance:

  _____

- Degree or Certificate (if any) Received:

  _____

- Name of school:

  _____

- Address:

  _____

- Years of Attendance:

  _____

- Degree or Certificate (if any) Received:

  _____

Please attach copies of any degrees or certificates.

Please attach signed and dated authorizations for release of education and academic records using the attached form.

VI. ADULT PERSONAL INJURY CLAIMS

Complete this section only if you are now an adult and have filed a claim for personal injuries.

1. Are you employed in any industry, craft or trade that works with lead?

   YES ____ NO _____

   1. If your answer to the foregoing question is "YES," please list every employer and the date(s) of such employment.

      _____

2. Have you ever been employed by, or worked directly as, a welder, painter, metal recycler, smelter, auto body repairperson, plumber, automotive repair, or in the construction industry?

   YES ____ NO ____

   1. If your answer to the foregoing question is "YES," please list every employer and the date(s) of such employment.

      _____

3. Have you ever received any home remedies or folk remedies for any conditions, illnesses, worship, or cultural celebrations?

   YES ____ NO ____

   1. If your answer to the foregoing question is "YES," please list every home remedy or folk remedy and the date(s) of your receipt here:

      _____
      _____
      _____
      _____

4. Do you claim that you have been injured because of exposure to lead in water distributed by the City of Jackson at any time since January 2015?

   YES _____ NO _____

1. If your answer to the foregoing question is "YES," please identify which of the following injuries you claim you suffered (as identified in Paragraph 59 of the Amended Complaint):

	Yes/No	Date of Onset	Diagnosing Physician/Healthcare Provider Name and Address	Treatment Prescribed if any
Hair Loss				
Skin Rashes				
Digestive and/or Other Organ Problems				
Physical Pain and Suffering				
Mental Anguish				
Fright and Shock				
Disability				
Denial of Social Pleasures and Enjoyments, Embarrassments, Humiliation and Mortification				
Brain and/or Developmental Injuries/Cognitive Deficits				
Aggravation of Pre-Existing Injuries (Identify the pre-existing injury you claim has been aggravated)				

2. If you claim any injury not identified above, please set forth below any additional injuries you claim you suffered because of exposure to lead in

water distributed by the City of Jackson, the diagnosing healthcare provider and address, date of onset, and treatment prescribed, if any:

3. If you answered "Yes" to question VI.D., state to the best of your knowledge each date on which you have undergone testing for lead levels, identify who took the sample to be tested, type of testing (e.g., blood lead, bone mineral study, hair analysis, urinalysis, tooth analysis), and provide the reported results of the testing.

	Test 1	Test 2	Test 3	Test 4
Date of Test for Lead?				
Who took the sample to be tested? (Lab/Facility/Healthcare Provider)				
Type of Testing (e.g., blood lead, bone mineral study, hair analysis, urinalysis, tooth analysis)				
Results of Test				

Please attach copies of any lead test results in your possession or control and any other documents (e.g., medical records) identifying test results in your possession or control.

E. Have you been told at any time by any health care provider that you have been injured as a result of lead in water distributed by the City of Jackson?

YES _____ NO _____

1. If "YES," please identify the health care provider, state exactly what you were told to the best of your ability and provide the date you were told this. (Attach additional sheets as necessary, and please attach copies of any statements by a health care provider made in writing).

- Name and Address of health care provider:

_____

- What were you told:

_____

- Dates and by whom:

_____

For each healthcare provider identified above, please complete the medical records authorization and mental health authorization attached hereto.

F. Do you claim you have suffered from any other illness because of exposure to water distributed by the City of Jackson at any time since January 2015?

YES: _____NO: _____

1. If "YES," please state what illness(es) you allege you have suffered because of exposure to water distributed by the City of Jackson.

_____

2. If you answered "yes" to section VI.F., please state whether you have been told by any health care provider that you have suffered from an illness which you believe was caused by exposure to water distributed by the City of Jackson at any time since January 2015. If so, please identify the health care provider(s), state exactly what you were told to the best of your ability and provide the date(s) you were told this. (Attach additional sheets as necessary). If no health care provider has told you or the adult on whose behalf you are completing this form that you or they suffered from any one or more of the illnesses you identified in answer to section VI.F. because of exposure to water distributed by the City of Jackson, state "None."

_____

G. Please identify each of your health care providers (including doctors, nurse practitioners, dentists, mental health care providers, and other health care professionals, institutions, hospitals, clinics, and urgent care facilities) from January 1, 2004, to the present in the table below and **attach signed and dated authorizations for release of medical records directed to each of these health care providers.**

Health Care Provider	Address	Treatment Dates	Reason for Treatment

For each healthcare provider identified above, please complete the medical records authorization and mental health authorization attached hereto.

VII. EDUCATION FOR ADULT

1. Are you currently enrolled in school?

YES: _____NO: ____

1. What is the highest level of education that you have completed: _____

2. Please list any schools you have attended (elementary, middle, junior high or high schools, junior colleges, vocational schools, universities, institutes, or seminaries):

- Name of school:

  _____

- Address:

  _____

- Years of Attendance:

  _____

- Degree or Certificate (if any) Received:

  _____

- Name of school:

- Address: _____

- Years of Attendance: _____

- Degree or Certificate (if any) Received: _____

Please attach any additional information, including copies of any degrees or certificates.

Please attach signed and dated authorizations for release of education and academic records directed to each school attended using the attached form.

VIII. SOCIAL SECURITY DISABILITY BENEFITS, HEALTH INSURANCE AND BANKRUPTCY (FOR BOTH CHILD AND ADULT)

1. SOCIAL SECURITY

Have you applied for or received social security disability benefits at any time since January 2015?

YES: _____ NO: _____

1. If "YES," state the date(s) when you applied for social security disability benefits and the dates, if any, for which such benefits were received:

- Date Application(s) Was Submitted: _____

- Dates For Which Benefits Received: _____

- State the basis for disability benefits: _____

If applicable, please attach a signed and dated authorization for release of social security disability records using the attached form.

2. HEALTH INSURANCE

1. Please provide for each of your health insurers since January 1, 2010 (attach additional sheets if necessary):

a. Name(s) of Insurer(s):

_____

b. Dates You Had Coverage with this Insurer(s):

_____

Please attach signed and dated authorizations for the release of records from all health insurers identified in your response to the above question using the attached form.

3. Have you filed bankruptcy?

YES _____ NO _____

1. Was the bankruptcy filed on or after January 1, 2015?

YES _____ NO _____

If "YES," please fill in the table below:

	Bankruptcy 1	**Bankruptcy 2**
Case Name and Number		
Jurisdiction		
Date of Filing		
Status		
Plaintiffs' Bankruptcy Counsel		

IX. LOST WAGES (FOR BOTH CHILD AND ADULT)

1. Are you claiming lost wages because of exposure to water distributed by the City of Jackson at any time since January 2015?

YES _____ NO: _____

2. If "YES," please describe the lost wages suffered by you, and identify each employer, state the relevant time, and estimate of the amount of your lost wages?

a. Names and Addresses of Employers:

_____

b. Dates of Employment at each Employer:

_____

If applicable, please attach signed and dated authorizations for the release of employment records directed to each employer as to whom you claim lost wages.

X. PROPERTY DAMAGE/LOSS CLAIMS (FOR BOTH CHILD AND ADULT)

Complete this section only if: (1) the person on whose behalf you are executing this Fact Sheet owns or leases or has owned or leased a property or residence since January 2015; and (2) you allege on behalf of said person damage to real estate, personal property, or associated plumbing because of the distribution of water from the City of Jackson to that property or residence since January 2015, and/or a related loss of income or value.

1. Please provide the address of each piece of real estate or a description of the personal property where you claim you have suffered such damage, state the dates of ownership of the property by you, and describe the nature of the damage.

Address or Description of Property	Dates of Ownership and Percentage of Ownership	Nature of Damage

1. State, with respect to each piece of real or personal property you have described in answer to X.A., the names and addresses of all other persons who had an ownership interest in the property at the time it was damaged:

_____

2. Does the person on whose behalf you are completing this PFS claim to have incurred expense to repair or replace damage caused by lead-contaminated City of Jackson water to real estate or personal property described in answer to subsection X.A.?

YES ____ NO _____

3. If you answered "Yes" to subpart X.A.2., state with respect to each piece of real estate or personal property that was damaged by lead-contaminated City of Jackson water the amount you or an insurer on your behalf paid to repair or replace the property:

_____

4. Does the person on whose behalf you are completing this PFS claim to have suffered a loss of rental or other income because of the distribution of water from the City of Jackson since January 2015?

YES _____NO _____

5. If you answered "Yes" to the preceding question, state the address of each piece of real estate for which you lost rental or other income since January 2015, and the net rental income produced by the property for each year between January 1, 2014, and January 1, 2024.

a. Address of rental property: _____

b. Net rental income/year:

- January 1, 2014-December 31, 2014: _____
- January 1, 2015-December 31, 2015: _____
- January 1, 2016-December 31, 2016: _____
- January 1, 2017-December 31, 2017: _____
- January 1, 2018-December 31, 2018: _____
- January 1, 2019-December 31, 2019: _____

- January 1, 2020-December 31, 2020: _____
- January 1, 2021-December 31, 2021: _____
- January 1, 2022-December 31, 2022: _____
- January 1, 2023-December 31, 2023: _____

B. Does the person on whose behalf you are executing this PFS claim to have suffered a reduction or diminution of property value because of the distribution of water from the City of Jackson since January 2015?

YES _____ NO _____

1. If you answered "Yes" to the preceding question, state the address of each piece of real estate for which you claim to have suffered a reduction or loss of property value since January 2015, the amount of such reduction, and the ownership interests since January 2015 (include the names and addresses of any other co-owners):

Address or Description of Property	**Amount of Such Reduction**	**Ownership Interests Since January 2015 (include names and addresses of any co-owners)**

C. Do you claim to have incurred out of pocket costs (such as costs to repair or replace damaged property) because of the distribution of water from the City of Jackson since January 2015?

YES _____ NO _____

1. If you answered "Yes" to the preceding question, state the address of each piece of real estate for which you claim to have incurred out of pocket costs since January 2015, and state with particularity what those costs are and when those costs were incurred:

Address or Description of Property	Detailed Description of Claimed Out-Of-Pocket Costs	Date(s) Out-Of-Pocket Costs Incurred

D. Have you made any insurance claims for the out-of-pocket costs you claim to have incurred?

_____YES _____NO

1. If you answered "Yes" to the preceding question, state the name of the insurance company to whom you made the claim, when the claim was made, and whether you received any benefits or reimbursement for your claimed out-of-pocket costs:

c. Name of Insurance Company: _____

d. Date Claim Was Made: _____

e. Amount of Benefits or Reimbursement Received: _____

VERIFICATION

I understand that the information I have provided in this Plaintiff's Fact Sheet will be used in relation to the lawsuit that has been filed on my behalf, or on behalf of the person for whom I have completed this Fact Sheet.

I declare under penalty of perjury under the laws of the State of Mississippi and the United States of America that the foregoing information is true and correct to the best of my knowledge and belief.

Date: _____

Name of Plaintiff: _____

Signature of Plaintiff: _____

Or

Date: _____

Name of Representative: _____

Signature of Representative: _____

REQUEST DOCUMENTS AND THINGS

Please produce the documents and things requested below, that are in your possession, custody, or control. If you withhold a document otherwise discoverable by claiming that it is privileged or otherwise protected, you shall make any such claim expressly and describe the nature of the information or document not produced or disclosed in a manner that enables other parties to assess the applicability of the privilege or protection, per Fed. R. Civ. P. 26(b)(5).

1. Please produce any documents in your possession constituting, concerning, or relating to your claims in this matter, including, but not limited to, instructions, warnings, handouts, flyers, brochures, or other materials provided to you or received from any governmental agency in connection with your claims in this matter.

2. Please produce any documents including copies in your possession of all printouts from websites you visited regarding your claims or regarding your injuries.

3. Please produce any documents including copies of transcripts in your possession of Internet chat room discussions in which you participated regarding your claims, your injuries and/or this lawsuit.

4. Please produce any documents including email in your possession relating to your claims, your injuries and/or this lawsuit.

5. Please produce any documents in your possession relating to any alleged health risks or hazards related to your claims at or before the time of your claimed injury.

6. Please produce any documents in your possession that you (and not your attorneys) obtained directly or indirectly from any of the Defendants in this matter.

7. Please produce any documents including all diaries, calendars, photographs, or any other writings or recordings in your possession made by you, or by any other person, describing, discussing, explaining or referring to the injuries, damages, or causes of action alleged by you in the Complaint and/or referring to the underlying illness or disease for which you seek compensation.

8. Please produce any documents in your possession that you (and not your attorneys) obtained from any source related to your claims in this lawsuit or to the alleged effects of exposure to lead.

9. Please produce any documents including copies of all medical records and bills from any physician, hospital pharmacy or other health care provider that are in your possession.

10. If this claim is a claim alleging a cause of action for wrongful death, please produce Decedent's death certificate (if applicable).

11. Please produce any documents in your possession related to any renovation(s), remodel(s), painting, demolition or construction occurring at any of the premises listed above, for any of the time periods listed above.

AUTHORIZATION TO DISCLOSE EDUCATIONAL INFORMATION

To:

I, the undersigned hereby authorize and request the above-named entity to disclose to the agents or designees of:

Butler Snow LLP, 1020 Highland Colony Pkwy, Ste. 1400, Ridgeland, MS 39157

Jones Walker LLP, 190 E Capitol Street, Ste. 800, Jackson, MS 39201

Daniels, Rodriguez, Berkeley, Daniels & Cruz P.A., 4000 Ponce De Leon Blvd., Ste. 800, Coral Gables, FL 33146

Fletcher & Sippel LLC, 4400 Old Canton Road, Ste. 220, Jackson, MS 39211-5982

collectively the "Defendants' Counsel" any and all records containing educational information, including those that may contain protected health information (PHI), regarding the identified as "Student" below, whether created before or after the date of signature. This authorization should also be construed to permit agents or designees of **the Defendants' Counsel** to copy, inspect and review any and all such records. Records requested may include, but are not limited to:

> all school records including application and admission paperwork, attendance records, transcripts, diplomas, health and physical examination records, immunization records, nurses' notes, disciplinary records, correspondence and any and all other information and records pertaining to the above-named individual. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information.

This authorization provides for the disclosure of the above-named individual's protected health information for purposes of the following litigation matter: *In re: Jackson Water Cases*, No. 3:23-CV-614-CWR-LGI, pending in the United States District Court for the Southern District of Mississippi (collectively the "Jackson Water Cases").

A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the final disposition of **the Jackson Water Cases.**

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, providing the revocation is in writing to the Defendants' Counsel, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to re-**

disclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.

- **The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.**

I have read this Authorization and understand that it will permit the entity identified to disclose PHI to **the Defendants' Counsel.**

Name of Student	Signature of Student or Representative
Former/Alias/Maiden Name of Student	Date
Student's Birth Date	Name of Student Representative
Student's Social Security Number	Description of Authority

Student's Address

Form **SSA-3288** (02-2023) UF
Discontinue Prior Editions
Social Security Administration

OMB No. 0960-0566

Consent for Release of Information

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). You may complete this form to release only the minor's non-medical records, if you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child. We require proof of relationship, if you are not the subject of the record. We may charge a fee for providing the information, if you are requesting the information for a purpose unrelated to the administration of a program under the Social Security Act. If you are requesting information, such as a Social Security Statement or benefit verification letter, you can also access this information by creating an account at https://www.ssa.gov/myaccount/.

NOTE: Do NOT use this form to request:

- **The release of a minor child's medical records. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or**
- **Detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.**

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form.

- Fill in the name, date of birth, and social security number of the subject of the record.
- Fill in the name and address of the person or organization of where you want us to send the requested information.
- Specify the reason you want us to release the information (e.g., litigation, investigation, determining eligibility for benefits). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child or legally incompetent adult, you must state how the release of information is in the best interest of the minor child or legally incompetent adult.
- Check the box next to the type(s) of information you want us to release including specific date ranges, where applicable.

NOTE: Unless otherwise specified, the consent form is valid for one-time use only. Also, it is valid for one year from the date of signature, unless you are requesting medical records. A consent form that includes a request for medical records is valid for 90 days from the date of signature.

Send or bring the completed form to the subject of the record's local servicing office. To locate the appropriate servicing office, visit https://secure.ssa.gov/ICON/main.jsp, and input the subject of the record's ZIP code.

Consent for Release of Information

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **These are not mandatory fields for the consent form to be acceptable. Please complete these fields in case we need to contact you about the consent form).*

TO: Social Security Administration

***Full Name**	***Date of Birth (MM/DD/YYYY)**	***Full Social Security Number**

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:**

***ADDRESS OF PERSON OR ORGANIZATION:**
**** PHONE NUMBER OF PERSON OR ORGANIZATION:**

***I want this information released because:**
We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**
Check at least one box. If requesting medical records, do not check both boxes 7 and 8. We will not disclose records unless you include specific date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ Social Security benefit amounts from date _____ to date _____
5. ☐ Supplemental Security Income payment amounts from date _____ to date _____
6. ☐ Medicare entitlement from date _____ to date _____
7. ☐ Medical records from date _____ to date _____
8. ☐ Complete medical records
9. ☐ Other Social Security record(s) (We will not honor a request for "any and all records" or "the entire file." You must specify which records you are seeking. For example, award/denial notices, benefit applications, appeals)

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 1746) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtains access to records about another person under false pretenses is punishable by a fine of up to $5,000.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

****Relationship (if not the subject of the record):** _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address (Number and street,City,State, and ZIP Code)	Address (Number and street,City,State, and ZIP Code)

Privacy Act Statement
Collection and Use of Personal Information

The Privacy Act (5 U.S.C. 552a) and Section 205(a) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from honoring the request to release information or records about you. We will use the information you provide to respond to the request for Social Security Administration (SSA) records. We may share the information for the following purposes, called routine uses:

- To contractors and other Federal agencies, as necessary, for the purpose of assisting SSA in the efficient administration of its programs.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0089, entitled Claims Folders System, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784; 60-0320, entitled Electronic Disability Claim File, as published in the FR on December 22, 2003, at 68 FR 71210; and 60-0340, entitled FOIA and Privacy Act Record Request and Appeal System, as published in the FR on July 13, 2016, at 81 FR 45352. Additional information, and a full listing of all our SORNs, is available on our website at www.ssa.gov/privacy.

Paperwork Reduction Act Statement

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 5 minutes to read the instructions, gather the facts, and answer the questions. You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

EMPLOYMENT AND PERSONNEL RECORDS RELEASE/AUTHORIZATION

I, _____, do hereby authorize and direct you to furnish, copy, deliver and/or otherwise permit inspection and access to any partner or associate or other such authorized representative of:

- Butler Snow LLP, 1020 Highland Colony Pkwy, Ste. 1400, Ridgeland, MS 39157
- Jones Walker LLP, 190 E Capitol Street, Ste. 800, Jackson, MS 39201
- Daniels, Rodriguez, Berkeley, Daniels & Cruz P.A., 4000 Ponce De Leon Blvd., Ste. 800, Coral Gables, FL 33146
- Fletcher & Sippel LLC, 4400 Old Canton Road, Ste. 220, Jackson, MS 39211-5982

collectively the "Defendants' Counsel", any and all personnel and/or employment records that you may have in any way pertaining to me, including but not limited to:

all applications for employment, resumes, records of all positions held, job descriptions of positions held, payroll records, W-2 forms and W-4 forms, performance evaluations and reports, statements and reports of fellow employees, attendance records, worker's compensation files; all hospital, physician, clinic, infirmary, nurse, dental records; test results, physical examination records and other medical records; any records pertaining to medical or disability claims, or work-related accidents including correspondence, accident reports, injury reports and incident reports; insurance claim forms, questionnaires and records of payments made; pension records, disability benefit records, and all records regarding participation in company-sponsored health, dental, life and disability insurance plans; material safety data sheets, chemical inventories, and environmental monitoring records and all other employee exposure records pertaining to all positions held; and any other records concerning employment with the above-named entity. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information.

By signing this authorization, I expressly do not authorize any *ex parte* interview or oral communication about me or my employment history.

My date of birth is _____ and my Social Security Number is _____.

This Authorization is to remain in effect, notwithstanding any rule, regulation, or policy of any records custodian until revoked by the undersigned, or until final disposition of the civil action styled *In re: Jackson Water Cases*, No. 3:23-CV-614-CWR-LGI, pending in the United States District Court for the Southern District of Mississippi (collectively the "Jackson Water Cases").

You are hereby requested to honor a photocopy of the Authorization as you would the original, notwithstanding any policy, rule and/or regulation of any to the contrary.

This _____ day of _____, 2024.

_____

Employee/Individual/Signee

AUTHORIZATION AND CONSENT
TO RELEASE RECORDS AND PROTECTED HEALTH INFORMATION
(Excluding psychotherapy notes)

Name of
Patient/Individual: _____

Social Security Number: _____

Date of Birth: _____

Provider Name:

Dates of Service: **January 1, 2004 - Present**

TO: All physicians, hospitals, clinics and institutions, pharmacists and other healthcare providers

The Veteran's Administration and all Veteran's Administration hospitals, clinics, physicians and employees

The Social Security Administration

The Internal Revenue Service

Open Records, Administrative Specialist, Department of Workers' Claims

All employers or other persons, firms, corporations, schools and other educational institutions

The undersigned individual hereby authorizes each entity included in any of the above categories to disclose and furnish to:

Butler Snow LLP, 1020 Highland Colony Pkwy, Ste. 1400, Ridgeland, MS 39157

Jones Walker LLP, 190 E Capitol Street, Ste. 800, Jackson, MS 39201

Daniels, Rodriguez, Berkeley, Daniels & Cruz P.A., 4000 Ponce De Leon Blvd., Ste. 800, Coral Gables, FL 33146

Fletcher & Sippel LLC, 4400 Old Canton Road, Ste. 220, Jackson, MS 39211-5982

(collectively **the "Defendants' Counsel"**) and their authorized representatives, true and correct copies of all records, reports, files, documents, correspondence, memoranda and all other information related to the physical and mental health of the undersigned individual, regardless of the form of such information, including, without limitation, all notes of physicians, nurses, psychologists, counselors, dentists and other persons who have provided or who are providing health care to the undersigned individual, all radiology, pathology (including HIV test results, genetic testing information, and alcohol and drug abuse treatment) and other diagnostic test and laboratory results, records and reports, all prescription records, all surgical procedure records and reports, all dental records, all histories and summaries, all forms and other information related to admission of the undersigned to or discharge of the undersigned from a clinic,

hospital or other health care facility, all surgical procedure and other consent forms, all bills, invoices, claim forms, records and other payment information, including payment by Medicaid/Medicare and other public assistance programs, insurance companies and by other persons. Notwithstanding the broad scope of the above disclosure request, the undersigned does not authorize the disclosure of "psychotherapy notes" as such term is defined by the Health Insurance Portability and Accountability Act, 45 CFR §164.501.

The undersigned also authorizes the disclosure of all records, reports, files, documents, correspondence, memoranda and all other information related to employment of the undersigned, including attendance reports, performance reports, W-2 and W-4 forms, medical reports and/or any and all other records relating to my past and present employment, and all educational records, including all courses taken, degrees obtained, and attendance records.

This authorization includes to the extent such records currently exist and are in the Provider's possession, employment records, workers' compensation records, disability records, social security records, and insurance records, including Medicare/Medicaid and other public assistance claims applications, statements, eligibility material, claims or claim disputes, resolutions and payments, medical records provided as evidence of services provided, and any other documents or things pertaining to services furnished under Title XVII of the Social Security Act or other forms of public assistance (federal, state, local, or other). This listing is not meant to be exclusive.

The above list of types of records and other information to be disclosed is intended to be illustrative and not exhaustive. This authorization does not authorize *ex parte* communication concerning same.

- This authorization provides for the disclosure of the above-named patient/individual's protected health information for purposes of the following litigation matter: *In re: Jackson Water Cases*, No. 3:23-CV-614-CWR-LGI, pending in the United States District Court for the Southern District of Mississippi (collectively the "Jackson Water Cases").

- The undersigned individual is hereby notified and acknowledges that any health care provider or health plan disclosing the above requested information may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

- The undersigned individual is hereby notified and acknowledges that he or she may revoke this authorization by providing written notice either to **the Defendants' Counsel** and/or to one or more entities listed in the above categories, except to the extent that any such entity has taken action in reliance on this authorization.

- The undersigned is hereby notified that he/she is aware that any and all protected health information disclosed and furnished to **the Defendants' Counsel** pursuant to this authorization will be shared with all any and all parties in the matter of **the Jackson Water Cases**, and is subject to redisclosure by the recipient for the purposes of this litigation in a manner that will not be protected by the Standards for the Privacy of Individually Identifiable Health Information contained in the HIPAA regulations (45 CFR §§164.500-164.534).

- I understand that information disclosed under this authorization could relate to, and I hereby authorize the disclosure of, information regarding treatment and testing for drug or alcohol abuse, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), sexually transmitted diseases, Sickle Cell Anemia, Tuberculosis and Genetic testing and counseling.

- A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the later of: (i) the date of settlement or final disposition of **the Jackson Water Cases.**

I have carefully read and understand the above and do hereby expressly and voluntarily authorize the disclosure of all of my above information to the Defendants' Counsel and their authorized representatives, by any entities included in the categories listed above.

Date: _____

_____
Signature of Patient/Individual or Patient/Individual's Representative

Patient's Name and Address:

_____
Printed Name of Patient/Individual's Representative (If applicable)

_____

_____
Relationship of Representative to Patient/Individual (If applicable)

_____

_____
Description of Representative's authority to act for Patient/Individual (If applicable)

This authorization is designed to be compliant with the Health Insurance Portability and Accountability Act, and the regulations promulgated thereunder, 45 CFR Parts 160 and 164 (collectively, "HIPAA").

AUTHORIZATION AND CONSENT
TO RELEASE PSYCHOTHERAPY NOTES

Name of
Patient/Individual:_____

Social Security Number: _____

Date of Birth: _____

Provider Name:

Dates of Service: **January 1, 2004 - Present**

TO: All physicians, hospitals, clinics and institutions, pharmacists and other healthcare providers

The Veteran's Administration and all Veteran's Administration hospitals, clinics, physicians and employees

The Social Security Administration

The Internal Revenue Service

Open Records, Administrative Specialist, Department of Workers' Claims

All employers or other persons, firms, corporations, schools and other educational institutions

The undersigned individual herby authorizes each entity included in any of the above categories to furnish and disclose to

Butler Snow LLP, 1020 Highland Colony Pkwy, Ste. 1400, Ridgeland, MS 39157

Jones Walker LLP, 190 E Capitol Street, Ste. 800, Jackson, MS 39201

Daniels, Rodriguez, Berkeley, Daniels & Cruz P.A., 4000 Ponce De Leon Blvd., Ste. 800, Coral Gables, FL 33146

Fletcher & Sippel LLC, 4400 Old Canton Road, Ste. 220, Jackson, MS 39211-5982

collectively the "Defendants' Counsel", and their authorized representatives, with true and correct copies of all "psychotherapy notes," as such term is defined by the Health Insurance Portability and Accountability Act, 45 CFR §164.501. Under HIPAA, the term "psychotherapy notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual's record. This authorization does not authorize *ex parte* communication concerning same.

This authorization provides for the disclosure of the above-named patient's protected health information for purposes of the following litigation matter: *In re: Jackson Water Cases*, No. 3:23-

CV-614-CWR-LGI, pending in the United States District Court for the Southern District of Mississippi (collectively the "Jackson Water Cases").

- The undersigned individual is hereby notified and acknowledges that any health care provider or health plan disclosing the above requested information may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

- The undersigned individual is hereby notified and acknowledges that he or she may revoke this authorization by providing written notice to either **the Defendants' Counsel,** and/or to one or more entities listed in the above categories, except to the extent that any such entity has taken action in reliance on this authorization.

- The undersigned is hereby notified that he/she is aware that any and all protected health information disclosed and furnished to **the Defendants' Counsel** pursuant to this authorization will be shared with any and all co-defendants in the matter of **the Jackson Water Cases** and is subject to redisclosure by the recipient for the purposes of this litigation in a manner that will not be protected by the Standards for the Privacy of Individually Identifiable Health Information contained in the HIPAA regulations (45 CFR §§164.500-164.534).

- A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the later of: (i) the date of settlement or final disposition of **the Jackson Water Cases**.

I have carefully read and understand the above and do hereby expressly and voluntarily authorize the disclosure of all of my above information to the Defendants' Counsel, and their authorized representatives, by any entities included in the categories listed above.

Date: _____

_____
Signature of Patient/Individual or Patient/Individual's Representative

Patient's Name and Address:

_____
Printed Name of Patient/Individual's Representative (If applicable)

_____

_____
Relationship of Representative to Patient/Individual (If applicable)

_____

_____
Description of Representative's authority to act for Patient/Individual (If applicable)

This authorization is designed to be compliant with the Health Insurance Portability and Accountability Act, and the regulations promulgated thereunder, 45 CFR Parts 160 and 164 (collectively, "HIPAA").

Form **SSA-7050-F4** (11-2022)
Discontinue Prior Editions
Social Security Administration

OMB No. 0960-0525

REQUEST FOR SOCIAL SECURITY EARNING INFORMATION

*Use This Form If You Need

1. **Certified/Non-Certified Detailed Earnings Information**
   Includes periods of employment or self-employment and the names and addresses of employers.

2. **Certified Yearly Totals of Earnings**
   Includes total earnings for each year but does not include the names and addresses of employers.

DO NOT USE THIS FORM TO REQUEST YEARLY EARNINGS TOTALS

Yearly earnings totals are free to the public if you do not require certification.

To obtain FREE yearly totals of earnings, visit our website at www.ssa.gov/myaccount.

Privacy Act Statement
Collection and Use of Personal Information

Section 205 of the Social Security Act, as amended, allows us to collect this information. In addition, the Budget and Accounting Act of 1950 and Debt Collection Act of 1982 authorize us to collect credit card information, if you choose to pay for the earnings information you have requested with a credit card. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from processing your request.

We will use the information to identify your records, process your request, and send the earnings information you request. We may also share the information for the following purposes, called routine uses:

1. To the Internal Revenue Service (IRS) for auditing SSA's compliance with the safeguard provisions of the Internal Revenue Code of 1986, as amended.

2. To contractors and other Federal agencies, as necessary, for the purpose of, assisting the Social Security Administration (SSA) in the efficient administration of its programs.

3. To banks enrolled in the Treasury credit card network to collect a payment or debt when the individual has given his/her credit card number for this purpose.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORNs) 60-0059, entitled Earnings Recording and Self-Employment Income System, 60-0090, entitled Master Beneficiary Record, 60-0224, entitled SSA-Initiated Personal Earnings and Benefit Estimate Statement, and 60-0231, entitled Financial Transactions of SSA Accounting and Finance Offices. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 11 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to:*** SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.

REQUEST FOR SOCIAL SECURITY EARNING INFORMATION

1. Provide your name as it appears on your most recent Social Security card or the name of the individual whose earnings you are requesting.

First Name: Middle Initial:

Last Name:

Social Security Number (SSN) One SSN per request

Date of Birth: Date of Death:

Other Name(s) Used
Maiden Name

2. What kind of earnings information do you need? (Choose **ONE** of the following types of earnings or SSA must return this request.)

☐ **Itemized Statement of Earnings $100.00**
(Includes the names and addresses of employers)
If you check this box, tell us why you need this information below.

Year(s) Requested: to
Year(s) Requested: to

☐ Check this box if you want the earnings information **CERTIFIED** for an additional $44.00 fee.

☐ **Certified Yearly Totals of Earnings $44.00**
(Does not include the names and addresses of employers)Yearly earnings totals are FREE to the public if you do not require certification. To obtain FREE yearly totals of earnings, visit our website at www.ssa.gov/myaccount.

Year(s) Requested: to
Year(s) Requested: to

3. If you would like this information **sent to someone else**, please fill in the information below.

I authorize the Social Security Administration to release the earnings information to:

Name

Address | State

City | ZIP Code

4. I am the individual to whom the record pertains (or a person authorized to sign on behalf of that individual).
I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature AND Printed Name of Individual or Legal Guardian | *SSA must receive this form within 120 days from the date signed*
Date

Relationship (if applicable, you must attach proof) | Daytime Phone:

Address | State

City | ZIP Code

Witnesses must sign this form ONLY if the above signature is by marked (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1. Signature of Witness | 2. Signature of Witness

Address *(Number and Street, City, State and ZIP Code)* | Address *(Number and Street, City, State and ZIP Code)*

REQUEST FOR SOCIAL SECURITY EARNING INFORMATION

INFORMATION ABOUT YOUR REQUEST

You may use this form to request earnings information for one ONE Social Security Number (SSN)

How do I get my earnings statement?

You must complete the attached form. Tell us the specific years of earnings you want, type of earnings record, and provide your mailing address. The itemized statement of earnings will be mailed to ONE address, therefore, if you want the statement sent to someone other than yourself, provide their address in section 3. Mail the completed form to SSA within 120 days of signature. If you sign with an "X", your mark must be witnessed by two impartial persons who must provide their name and address in the spaces provided. Select **ONE** type of earnings statement and include the appropriate fee.

1. Certified/Non-Certified Itemized Statement of Earnings
This statement includes years of self-employment or employment and the names and addresses of employers.

2. Certified Yearly Totals of Earnings
This statement includes the total earnings for each year requested but *does not* include the names and addresses of employers.

If you require one of each type of earnings statement, you must complete two separate forms. Mail each form to SSA with one form of payment attached to each request.

How do I get someone else's earnings statement?

You may get someone else's earnings information if you meet one of the following criteria, attach the necessary documents to show your entitlement to the earnings information and include the appropriate fee.

1. Someone Else's Earnings
The natural or adoptive parent or legal guardian of a minor child, or the legal guardian of a legally declared incompetent individual, may obtain earnings information if acting in the best interest of the minor child or incompetent individual. You must include proof of your relationship to the individual with your request. The proof may include a birth certificate, court order, adoption decree, or other legally binding document.

2. A Deceased Person's Earnings
You can request earnings information from the record of a deceased person if you are:
- The legal representative of the estate;
- A survivor (that is, the spouse, parent, child, divorced spouse of divorced parent); or
- An individual with a material interest (e.g., financial) who is an heir at law, next of kin, beneficiary under the will or donee of property of the decedent.

You must include proof of death and proof of your relationship to the deceased with your request.

Is There A Fee For Earnings Information?

Yes. We charge a $100.00 fee for providing information for purposes unrelated to the administration of our programs.

1. Certified or Non-Certified Itemized Statement of Earnings
In most instances, individuals request Itemized Statements of Earnings for purposes unrelated to our programs such as a private pension plan or personal injury suit. Bulk submitters may email OCO.Pension.Fund@ssa.gov for an alternate method of obtaining itemized earnings information.

We will **certify** the itemized earnings information for an additional $44.00 fee. Certification is usually not necessary unless you are specifically requested to obtain a certified earnings record.

Sometimes, there is no charge for itemized earnings information. If you have reason to believe your earnings are not correct (for example, you have previously received earnings information from us and it does not agree with your records), we will supply you with more detail for the year(s) in question. Be sure to show the year(s) involved on the request form and explain why you need the information. If you do not tell us why you need the information, we will charge a fee.

2. Certified Yearly Totals of Earnings
We charge $44.00 to certify yearly totals of earnings. However, if you do not want or need certification, you may obtain yearly totals *FREE* of charge at www.ssa.gov/myaccount. Certification is usually not necessary unless you are advised specifically to obtain a certified earnings record.

Method of Payment
This Fee Is Not Refundable. DO NOT SEND CASH.

You may pay by credit card, check or money order.
- Credit Card Instructions
  Complete the credit card section on page 4 and return it with your request form.

- Check or Money Order Instructions
  Enclose one check or money order per request form payable to the Social Security Administration and write the Social Security number in the memo.

How long will it take SSA to process my request?

Please allow SSA 120 days to process this request. After 120 days, you may contact 1-800-772-1213 to leave an inquiry regarding your request.

REQUEST FOR SOCIAL SECURITY EARNING INFORMATION

- **Where do I send my complete request?**

Mail the completed form, supporting documentation, and applicable fee to: **Social Security Administration** P.O. Box 33011 Baltimore, Maryland 21290-33011	If using private contractor such as FedEx mail form, supporting documentation, and application fee to: **Social Security Administration** P.O. Box 33011 Baltimore, Maryland 21290-33011

- **How much do I have to pay for an Itemized Statement of Earnings?**

Non-Certified Itemized Statement of Earnings	**Certified** Itemized Statement of Earnings
$100.00	$144.00

- **How much do I have to pay for Certified Yearly Totals of Earnings?**

Certified yearly totals of earnings cost $44.00. You may obtain non-certified yearly totals FREE of charge at www.ssa.gov/myaccount. Certification is usually not necessary unless you are specifically asked to obtain a certified earnings record.

YOU CAN MAKE YOUR PAYMENT BY CREDIT CARD

As a convenience, we offer you the option to make your payment by credit card. However, regular credit card rules will apply. You also pay by check or money order. Make check payable to Social Security Administration.

CHECK ONE	☐ Visa ☐ American Express ☐ MasterCard ☐ Discover
Credit Card Holder's Name (Enter the name from the credit card)	First Name, Middle Initial, Last Name
Credit Card Holder's Address	Number & Street City, State, & ZIP Code
Daytime Telephone Number	Area Code
Credit Card Number	
Credit Card Expiration Date	(MM/YY)
Amount Charged See above to select the correct fee for your request. Applicable fees are $44.00, $100.00, or $144.00. SSA will return forms without the appropriate fee.	$
Credit Card Holder's Signature	Date

DO NOT WRITE IN THIS SPACE **OFFICE USE ONLY**	Authorization	
	Name	Date
	Remittance Control #	

Form **4506**

(Novmeber 2021)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed.**
▶ **Request may be rejected if the form is incomplete or illegible.**
▶ **For more information about Form 4506, visit *www.irs.gov/form4506.***

OMB No. 1545-0429

Tip: Get faster service: Online at www.irs.gov, **Get Your Tax Record** (Get Transcript) or by calling **1-800-908-9946** for specialized assistance. We have teams available to assist. **Note:** Taxpayers may register to use Get Transcript to view, print, or download the following transcript types: **Tax Return Transcript** (shows most line items including Adjusted Gross Income (AGI) from your original Form 1040-series tax return as filed, along with any forms and schedules), **Tax Account Transcript** (shows basic data such as return type, marital status, AGI, taxable income and all payment types), **Record of Account Transcript** (combines the tax return and tax account transcripts into one complete transcript), **Wage and Income Transcript** (shows data from information returns we receive such as Forms W-2, 1099, 1098 and Form 5498), and **Verification of Non-filing Letter** (provides proof that the IRS has no record of a filed Form 1040-series tax return for the year you request).

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

Caution: If the tax return is being sent to the third party, ensure that lines 5 through 7 are completed before signing. (see instructions).

6 **Tax return requested.** Form 1040, 1120, 941, etc. and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ _____

Note: If the copies must be certified for court or administrative proceedings, check here . . . . . ☐

7 **Year or period requested.** Enter the ending date of the tax year or period using the mm/dd/yyyy format (see instructions).

____/____/_____ ____/____/_____ ____/____/_____ ____/____/_____

____/____/_____ ____/____/_____ ____/____/_____ ____/____/_____

8	**Fee.** There is a $43 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN, ITIN, or EIN and "Form 4506 request" on your check or money order.**	
a	Cost for each return	$
b	Number of returns requested on line 7	
c	Total cost. Multiply line 8a by line 8b	$

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here . . . . . ☐

Caution: *Do not sign this form unless all applicable lines have been completed.*

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506.** See instructions.

Sign Here	▶ **Signature** (see instructions)	Date
	▶ Print/Type name	**Title** (if line 1a above is a corporation, partnership, estate, or trust)
	▶ **Spouse's signature**	Date
	▶ Print/Type name	

Phone number of taxpayer on line 1a or 2a

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about Form 4506 and its instructions, go to *www.irs.gov/form4506*.

General Instructions

Caution: Do not sign this form unless all applicable lines, *including lines 5 through 7*, have been completed.

Designated Recipient Notification. Internal Revenue Code, Section 6103(c), limits disclosure and use of return information received pursuant to the taxpayer's consent and holds the recipient subject to penalties for any unauthorized access, other use, or redisclosure without the taxpayer's express permission or request.

Taxpayer Notification. Internal Revenue Code, Section 6103(c), limits disclosure and use of return information provided pursuant to your consent and holds the recipient subject to penalties, brought by private right of action, for any unauthorized access, other use, or redisclosure without your express permission or request.

Purpose of form. Use Form 4506 to request a copy of your tax return. You can also designate (on line 5) a third party to receive the tax return.

How long will it take? It may take up to 75 calendar days for us to process your request.

Where to file. Attach payment and mail Form 4506 to the address below for the state you lived in, or the state your business was in, when that return was filed. There are two address charts: one for individual returns (Form 1040 series) and one for all other returns.

If you are requesting a return for more than one year or period and the chart below shows two different addresses, send your request based on the address of your most recent return.

Chart for individual returns (Form 1040 series)

If you filed an individual return and lived in:	Mail to:
Florida, Louisiana, Mississippi, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team Stop 6716 AUSC Austin, TX 73301
Alabama, Arkansas, Delaware, Georgia, Illinois, Indiana, Iowa, Kentucky, Maine, Massachusetts, Minnesota, Missouri, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, South Carolina, Tennessee, Vermont, Virginia, Wisconsin	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999
Alaska, Arizona, California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kansas, Maryland, Michigan, Montana, Nebraska, Nevada, New Mexico, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Washington, West Virginia, Wyoming	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409

Chart for all other returns

For returns not in Form 1040 series, if the address on the return was in:	Mail to:
Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409

Specific Instructions

Line 1b. Enter the social security number (SSN) or individual taxpayer identification number (ITIN) for the individual listed on line 1a, or enter the employer identification number (EIN) for the business listed on line 1a. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 3. Enter your current address. If you use a P.O. box, please include it on this line 3.

Line 4. *Enter the address shown on the last return* filed if different from the address entered on line 3.

Note. If the addresses on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address, or Form 8822-B,Change of Address or Responsible Party — Business, with Form 4506.

Line 7. Enter the end date of the tax year or period requested in mm/dd/yyyy format. This may be a calendar year, fiscal year or quarter. Enter each quarter requested for quarterly returns. Example: Enter 12/31/2018 for a calendar year 2018 Form 1040 return, or 03/31/2017 for a first quarter Form 941 return.

Signature and date. Form 4506 must be signed and dated by the taxpayer listed on line 1a or 2a. The IRS must receive Form 4506 within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines, *including lines 5 through 7*, are completed before signing.

CAUTION *You must check the box in the signature area to acknowledge you have the authority to sign and request the information. The form will not be processed and returned to you if the box is unchecked.*

Individuals. Copies of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506 exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506 can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer. A bona fide shareholder of record owning 1 percent or more of the outstanding stock of the corporation may submit a Form 4506 but must provide documentation to support the requester's right to receive the information.

Partnerships. Generally, Form 4506 can be signed by any person who was a member of the partnership during any part of the tax period requested on line 7.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Note: If you are Heir at law, Next of kin, or Beneficiary you must be able to establish a material interest in the estate or trust.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the letters testamentary authorizing an individual to act for an estate.

Signature by a representative. A representative can sign Form 4506 for a taxpayer only if this authority has been specifically delegated to the representative on Form 2848, line 5a. Form 2848 showing the delegation must be attached to Form 4506.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested return(s) under the Internal Revenue Code. We need this information to properly identify the return(s) and respond to your request. If you request a copy of a tax return, sections 6103 and 6109 require you to provide this information, including your SSN or EIN, to process your request. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506 will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form,** 10 min.; **Preparing the form,** 16 min.; and **Copying, assembling, and sending the form to the IRS,** 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506 simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service
Tax Forms and Publications Division
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224.

Do not send the form to this address. Instead, see *Where to file* on this page.